



**APPLICATION/NOMINATION FOR
COSMETOLOGY, BARBER, ESTHETICIAN, AND MANICURIST
ADVISORY BOARD APPOINTMENT**

Please attach résumé if available

Name _____

Social Security No. _____ Legislative District _____

Home Street Address _____

City _____ State _____ Zip _____ Home Telephone (____) _____

Email Address _____

Business Street Address _____

City _____ State _____ Zip _____ Work Telephone (____) _____

Education *(high school, name and location of college/university, year graduated, degree)*

Licenses held *(if applicable to specific board/commission)*

Present employment *(job title, date of employment, description of duties)*

Previous employment/experience *(include dates)*

Memberships in professional/community organizations *(list offices held and date of term)*

References *(name, address, phone, context of knowledge)*

Personal Information

☐ Female ☐ Male

Of what race or ethnicity do you consider yourself to be?

☐ Black/African-American

☐ Asian or Pacific Islander American

*If you are Asian or Pacific Islander,
please check one box below:*

☐ Chinese

☐ Vietnamese

☐ Filipino

☐ Asian Indian

☐ Korean

☐ Japanese

☐ Other: _____

☐ White/Caucasian

☐ American Indian or Alaska Native

*If you are American Indian or Alaska
Native, please check one box below:*

☐ Eskimo

☐ Aleut

Enrolled or principal tribe if American
Indian

Tribe: _____

☐ Latino(a), Hispanic, or Spanish?

*If you are Latino(a), Hispanic, or
Spanish, please check one box below:*

☐ Mexican, Mexican-American, Chicano

☐ Puerto Rican

☐ Cuban

☐ Other Latino(a), Hispanic, or Spanish

*Enter group, such as Colombian,
Dominican, etc.*

Group: _____

☐ Other Race: _____

Do you have a permanent physical, sensory, or mental condition that limits your major life functions, such as working, caring for yourself, walking, doing things with your hands, seeing, hearing, speaking, and learning? ☐ Yes ☐ No

If "Yes," please attach an explanation to this application.

The above information is optional and not necessary to complete your application.

Signature of applicant **X** _____ Date _____

Recommended by _____

Return completed form to:

**DEPARTMENT OF LICENSING
COSMETOLOGY SECTION
PO BOX 9026
OLYMPIA, WA 98507-9026**